determined separately and, by examining a mixture of all samples, the "average acidity" is ascertained. This method is advocated as being superior to the so-called "fractional method," where only a small sample is withdrawn, which may not be representative of the contents remaining in the stomach. The author feels that the "secretory variations" revealed by the "fractional" method of gastric analysis may be explained in part by the fact that the acidity of the fractions removed represents only the acidity of the chyme at the moment of removal in those parts of the stomach from which they were obtained as above.

Paroxysmal Tachycardia of Ventricular Origin, and its Relation to Coronary Occlusion.—ROBINSON, G. C., and HERRMAN, G. R. (*Heart*, 1921, viii, 59). On reviewing 16 reported cases of paroxysmal tachycardia of ventricular origin in which electrocardiograms are published these authors find only 6 undoubted cases. Six others are classified as probable cases of ventricular paroxysmal tachycardia. To this first group (undoubted cases) they add 4 of their own cases. Attention is called to the proved relationship between ventricular paroxysmal tachycardia and coronary occlusion in experimental animals. In one of the 4 human cases herein reported direct evidence of the association of ventricular paroxysmal tachycardia with coronary occlusion was obtained at autopsy. It is felt (for reasons cited) that this relationship was probably present in the remaining 3 cases. The prognosis of paroxysmal tachycardia of ventricular origin is more unfavorable (3 of the 4 cases dying) than that of auricular origin.

Jaundice after Salvarsan.—BROCQ, L. (*Bull. médical, Paris*, 1921, xxxv, 235). The author notes that jaundice following intravenous neoarsphenamine treatment indicates injury to liver cells, which, if not subjected to further damage, soon recover. However, these damaged cells offer a *locus minoris resistentiæ* for spirochetes, so that a complete suspension of treatment seems contraindicated. He suggests, in such a dilemma, the use of mercury or of neoarsphenamine subcutaneously, and insists that in either case the procedure must be carried out with the greatest caution.

SURGERY

UNDER THE CHARGE OF

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Pericardiotomy for Suppurative Pericarditis.—POOL (*Ann. of Surg.*, 1921, lxxiii, 393) says that two features have become generally accepted, first approach and drainage should be to the left of the sternum, secondly

no procedure should be employed which does not drain the lowest part of the pericardium. He offers an improved method—resection of portions of seventh, sixth and fifth cartilages, wherein the pericardium is opened at its lowest point; little risk to the pleura is involved, while ample drainage is provided. Moreover, whatever exploration is necessary either at the time of operation or postoperatively is provided for the added fourth interspace is exceedingly wide. Resection of the sixth and the seventh cartilages seems best in cases where less extensive exposure is imperative. Indeed, this procedure was used in the author's case, giving satisfactory exposure and efficient drainage. The drain was removed in thirty-six hours in the reported case with the substitution of two Carrel tubes and Dakin's solution was introduced regularly. In another case Carrel-Dakin method would be instituted immediately. From former experience and study of case reports, it was felt that thick pus with fibrin would likely wall off the cavity into chambers with resulting retained excretions and subsequent imperfect drainage, especially of the left recess. In theory, it was believed that the solvent effect of Dakin's solution would obviate this risk by rendering the excretions thin. Improvement was striking and sustained, while there was no noxious influence exerted upon the pericardium apparently. Early treatment with Dakin's solution may possibly diminish pericardial adhesions. Resection of sixth cartilage alone may be done readily under local anesthesia and is indeed tempting, by reason of its simplicity, but drainage is not sufficient.

Gastro-enterostomy in Acute Perforated Ulcer of Stomach and Duodenum.—DEAVER and PFEIFFER (*Ann. of Surg.*, 1921, lxxiii, 441) say that all success in perforated ulcer is based on early treatment—early operation and efficient suture of the opening are essential. In subsidiary measures excision of the ulcer offers nothing of immediate life-saving value, while primary gastro-enterostomy is still a debated issue. The senior author has performed primary gastrojejunostomy for fifteen years with very satisfactory end results in a large series of 67 cases. The chief contraindication is the presence of shock or evident systemic toxemia—not frequent within twelve hours after perforation.

Congenital Torticollis.—MEYERDING (*Jour. Orthopedic Surgery*, 1921, iii, 91) says that torticollis of congenital origin is a deformity rarely met with in the general practice of medicine and surgery. The etiologic factor appears to be trauma to the sternocleidomastoid muscle at or preceding birth, producing an ischemia with resulting chronic interstitial myositis. Heredity, infection and syphilis do not seem to be factors. The treatment is surgical as early as possible with subsequent retentive apparatus. Operative technic is outlined.

Hallux Valgus Rigidus and Malleus.—JANSEN (*Jour. Orthopedic Surgery*, 1921, iii, 87) says that two principles make themselves felt in these deformities: (1) disturbance of muscle balance—most prominent in hallux valgus and (2) joint wear, the arthritis deformans of textbooks—most prominent in hallux rigidus. This latter condition is characterized by flattening of the metatarsal head with gradual shorten-